Great Western Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection between 21 and 23 March 2017 and an unannounced inspection at Great Western Hospital on 26, 27 and 28 March 2017 and 3 April 2017. This was a focused inspection to follow up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following six core services at Great Western Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Services for children and young people
- Outpatients and diagnostic imaging

We also inspected:

- Urgent care services (provided as a community service).

We did not inspect end of life care or maternity and gynaecology services (previously rated good). We did not inspect the effective, caring or responsive domains for services for children and young people (previously rated good). The effective domain was inspected but not rated for outpatients and diagnostic imaging.

Overall we rated Great Western Hospitals NHS Foundation Trust as requires improvement.

We have deviated from the aggregation principles by not aggregating the ratings for (community) urgent care services to the overall trust rating. This is in recognition of the fact that, at the time of our inspection, the trust had only been running these services for six months. We also deviated from the aggregation principles for the well led rating at provider level. Please see the well led section below.

Safe

We rated the safe domain as requires improvement overall. Urgent and emergency services, medical care, surgery, critical care, services for children and young people, the urgent care centre and outpatients and diagnostic imaging were all rated as requires improvement.

- As a result of high demand we found the emergency department was frequently full, with patients in all cubicles and around the nurses' station. There were occasions where the emergency department was deemed to be unsafe as a result of the number of patients within the department. However, this was improving. We also found that as a result of pressures for beds in surgery some patients had to use facilities which were not always appropriate for recovering from their surgery.
- The checking of temperatures for medicines needed to be improved. Daily checks of medicines were not always completed in the emergency department or critical care. We found in medical care that some areas did not have regular temperature checks. This meant that medicines used may not have been fit for use due to the temperatures they may have been stored at outside of the recommended temperature range.
- The storage of medicines needed to be improved. In medical care we found that some of the storage shelves did not allow for stock rotation, which increased the risk of medicines being out of date. In the urgent care centre medicines which should have been locked away were not. We also found in critical care that the fridges used to store medicines could not be locked. This meant that medicines could be removed without authorisation.
- Equipment used was not always checked in line with guidance to ensure it was fit for purpose. Daily checks of equipment did not always take place for emergency equipment. There were some days where checks were not recorded for the paediatric intubation trolley in the emergency department and the emergency equipment trolleys in critical care. We also found in the service for children and young people that heated water blankets did not have expiry dates or water change dates recorded.
- There were areas throughout the hospital which did not have sufficient numbers of suitably qualified staff on shift to keep people safe. This included the emergency department observation unit where we observed a patient walking out of the department without staff knowing. Within medical care, services for children and young people, surgery and critical care there were wards and theatres which went through

Summary of findings

periods of understaffing which meant that staffing numbers did not always meet national guidelines. In medical care we found that ambulatory care was sometimes left with no staff in it for short periods of time due to lone working arrangements.

- Mandatory training rates needed to be improved in the emergency department for medical staff, in the urgent care centre, medical care, outpatients and diagnostic imaging, critical care, and surgery. In services for children and young people all medical staff fell below trust targets for all mandatory training and paediatric basic life support training was below target in all staff groups.
- Safeguarding practices needed to be improved in the urgent care centre, outpatients and diagnostic imaging and in services for children and young people. In outpatients and diagnostic imaging only 20% of medical and dental staff had completed level two safeguarding adults training against a trust target of 80%. In the urgent care centre no one was level three trained for children's safeguarding. In services for children and young people staff did not have ready access to relevant safeguarding information on a patient due a filing backlog.
- The security and completeness of records needed to be been improved. We found in medical care and critical care that patient records were not always stored securely. We also found that in critical care patient allergies and venous flushes were not always documented. In medical care we found that not all patient documentation was completed in full and handovers between wards was not consistency provided to a high standard. This meant that patients' full needs were not always met.

However:

- There was a positive incident reporting culture and openness and transparency was encouraged. Opportunities for learning were sought when an incident occurred and learning was shared between teems. Where never events occurred in surgery we found they were investigated fully and actions had been taken to prevent them from happening again.
- We found all areas within the hospital, apart from a few exceptions, were visibly clean and tidy. We saw staff following National Institute of Health and Care Excellence standards for hand hygiene and we found that audit results were positive.
- We found that staffing levels for both medical and nursing staff were in line with recommended guidance in the emergency department, critical care and the urgent care centre. Within medical care there were sufficient doctors to provide safe care for patients.
- Risks to patients were appropriately assessed in the emergency department where we found observations and treatment decisions were made in a timely way. We found that patients' records were legible, complete, up to date and accurate in the emergency department, surgery, and critical care.

Effective

We rated the effective domain as good overall. It was rated as good for urgent and emergency care, surgery, critical care. It was rated as requires improvement for medical care and the urgent care services. It was inspected but not rated for outpatients and diagnostic imaging.

- In the emergency department, medical care, surgery, critical care and outpatients and diagnostic imaging we found that patients' care and treatment were planned and delivered in line with guidance, standards, best practice and legislation. This included guidance from the National Institute of Care Excellence and the Royal College of Emergency Medicine.
- Information about patients' care and treatment was routinely monitored and action was taken to improve the effectiveness of treatment where shortfalls had been identified. In surgical services the trust had a better rate of re-admission compared to the national average. In emergency care the department performed well in the latest Royal College of Emergency Medicine audits.
- Staff had the skills required to carry out their roles effectively. In all services inspected we found that staff had qualifications, experience and had received competency training in line with their role requirements. Most services performed better than the trust target for completion of appraisals.
- Patients received care and treatment from different disciplines who worked together in a coordinated way. All departments communicated well with each other to ensure effective treatment for patients. This

Summary of findings

multidisciplinary working approach continued over weekends where there were 24 hour diagnostics, critical care outreach, physiotherapy, pharmacy, and mental health liaison services.
- Within all services we found that the nutritional and hydration need of patients were fully assessed and that actions were taken to address concerns as soon as they were identified. Within the trauma unit innovative systems were in place to improve nutrition and hydration for patients.

However:

- In the urgent care centre policies, protocols and patient pathways were not in line with best practice legislation. Many policies were out of date, with some of them being several years out of date.
- In some areas of the trust outcomes required improvement. In medical care areas of the national stroke audit, MINAP audit and the national heart failure audit required improvement. In the urgent care centre outcomes were not routinely collected but were being introduced after the inspection.
- In critical care the provision of therapy services did not meet national standards. We found there was insufficient access to physiotherapy and dietetic services.

Caring

We rated the caring domain as good in medical care, surgery, critical care, outpatients and diagnostic imaging, and the urgent care centre. In urgent and emergency care we rated caring as outstanding.

- In all areas feedback from patients was consistently positive. We spoke withpatients their relative whotold us they recived care that was compassionate, they were involved as partners in care, and supported to cope emotionally with their care.
- Inspectors observed patients being treated with kindness and respect and saw that patients and their relatives were active partners in their care. They were well informed of treatment options and were involved in decision making.
- Emotional support was available to patients, either through the use of a psychiatric liaison nurse orstaff taking the time to sit with patients and talk to them. There were good examples of staff listening and acting appropriately to patients suffering from emotional distress.

However:

- Privacy and dignity was compromised in the discharge lounge, the surgical assessment unit, theatre recovery, ophthalmology and the urgent care centre. Conversations with patients could be overheard in the urgent care centre assessment rooms, the discharge lounge and the ophthalmology department. We found that in the surgical assessment unit, the discharge lounge and theatre recovery privacy was difficult to maintain when a patient required the toilet or to use a bedpan.

Responsive

We rated the responsive domain as requires improvement overall. It was rated as requires improvement for urgent and emergency care, medical care, surgery and outpatients and diagnostic imaging. It was rated as good for critical care and the urgent care centre.

- Patient flow through the hospital required improvement. The trust found it difficult to discharge patients from medical, surgical, and critical care services who required social care or patients who had a complex discharge.
- This resulted in the emergency department regularly being full to capacity, which meant that patients could not be seen in a timely way for assessment or treatment. The emergency department regularly breached targets for time spent in the department with most breaches being attributable to beds throughout the rest of the hospital not being available.
- Although medical outliers were managed well, the number of them was impacting the number of elective operations which could take place.
- Facilities were not always fit for purpose as a result of the numbers of patients being treated at the hospital. The medical expected unit was not always able to separate male and female patients, compromising privacy and dignity. In the emergency department patients were regularly cared for around the nursing station without screens to protect their privacy and dignity.

Summary of findings

- For three months out of the past 10 the trust was performing worse than the national standard for two week urgent cancer referrals There were a high number of patients waiting for non-cancer outpatient appointments, with the most in ophthalmology. There were also delays in the sending out of letters for patients after their appointment.
- We found that in medical care and outpatients and diagnostic imaging translation services were available, but they were not always utilised. In medical care relatives were sometimes used with compromised confidentiality.

However:

- A number of steps had been taken to improve patient flow. This included moving the ambulatory care service to increase capacity and the introduction of the medical expected unit. There were also effective patient flow meetings to establish who could be discharged.
- High numbers of patients were streamed from the emergency department to the urgent care centre. We found that the urgent care centre was seeing patients quickly and seeing them within four hour targets.
- Reasonable adjustments were made to support patients in vulnerable circumstances throughout the hospital. Staff had a good understanding of the adjustments needed to support people living with dementia and learning disabilities.

Well Led

We rated the well led domain as good overall. It was rated as good for urgent and emergency care, medical care, critical care, outpatients and diagnostic imaging and the urgent care centre. It was rated as requires improvement for services for surgery and children and young people. We have deviated from our ratings aggregation principles in recognition of the significant improvements made since our last inspection. There was good board oversight of quality, safety and the trust's financial situation, which had improved. Significant challenges in respect of capacity, access and flow were well understood. The trust was working with partners to address these challenges to ensure future sustainability of healthcare in Swindon.

- There was a clear vision and strategy within the services which was underpinned by realistic goals. The urgent care centre was working to develop its strategy in line with the unscheduled care division. This strategy was being acted upon with innovative workstreams through the emergency department, medical care, surgery, services for children and young people and outpatients and diagnostic imaging.
- Governance functioned effectively within all of the core services inspected and where reviews were underway (in services for children and young people and the urgent care centre) there were clear timescales and actions.
- Leaders of services throughout the organisation had a good understanding of the challenges faced by their departments and had the knowledge, skills and experience to lead effectively. Staff throughout the organisation spoke positively about their leaders and were confident to go to them if needed.

However:

- Staff within services for children and young people felt disconnected from the rest of the trust. The leadership had not been embedded locally and there was no representation of services for children and young people on the board.
- Nurses in services for children and young people did not recognise the trust as a good place to work. We were told that they often had to work long hours without access to a drink and without having a break. Nurses did not know the strategy of the women's and children's division.
- In surgery there were areas where there was a lack of management oversight. Also, actions identified to mitigate risks on the risk register were not always effective.
- In the emergency department, and surgical services staff felt that the executive team was not visible enough and that attempts to engage with staff could be better.

We saw several areas of outstanding practice including:

- The work of the education lead in the emergency department to improve education through various initiatives and work steams, including improved appraisals, training as part of the governance days and introduction of structured workbooks and teaching sessions.

Summary of findings

- The understanding and involvement of patients and those close to them in the paediatric emergency department we observed during triage. The nurse put patients at ease and made sure that the process was explained in a compassionate way.
- The understanding of the emergency department leadership team of performance, governance, risks and its impact on patient care.
- The use of an emergency department monthly governance day to engage staff with governance and learning from incidents, concerns or near misses.
- The use of social media in the emergency department to engage staff to be more engaged with governance, share learning and discuss concerns with senior members of staff.
- The work of the clinical trials team in the emergency department to increase trial recruitment from very few patients a year to several hundred patients a year and the impact this has had on patient experience in the department.
- The medical care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The medical care service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The trauma unit within surgery provided a picture menu which showed photographs of all food options that the hospital provided. This could be used for patients with communication difficulties, such aspatients with learning difficulties so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.
- The outpatient service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The outpatient service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The monthly staff newsletter in the urgent care centre contained information on departmental news, department performance and updates on policies and procedures.
- The trust had introduced acute neurology clinics, located close to the short stay/ambulatory care unit, for patients who attended the acute medical unit and would have needed to be admitted in the past for further opinions and tests. These patients could now be discharged with an appointment, either the following day or the day after. This initiative had led to a significant number of admissions being avoided and provided a positive experience for patients.
- The cardiology department inserted the first four lead pacemaker for a patient in the world. The medical staff were monitoring the patient's recovery and rehabilitation as part of an international research project to assess the advantages of the new technology.
- A GP was employed in ambulatory care four days a week. The purpose of this new position was to improve communication with GPs to ensure basic tests had been completed prior to the patient attending the ambulatory care unit. It was anticipated that this would help to increase the flow of patients through the department and prevent patients attending the unit unnecessarily.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that the emergency department observation unit is sufficiently staffed to keep people safe.
- Ensure that medical staff in the emergency department receive appropriate mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that daily checks are conducted on resuscitation equipment and medicine fridges in the emergency department to assess that they are safe to use.
- Continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department at pace to improve safety and patient flow in the department.
- Ensure the promotion and control of infection at all times and in all areas within medical care.

Summary of findings

- Ensure the security of patients' confidential and personal information at all times within medical care.
- Ensure the safety of patients at all times within medical care, including ensuring sufficient staff are on duty to monitor and provide care and treatment to the patients. The trust should ensure patients are not left unattended in the ambulatory care department as a result of staff lone working.
- Ensure that the privacy and dignity of patients in medical care is respected and ensure that breaches of the national mixed sex accommodation do not occur.
- Ensure that staff in medical care consistently meet the trust target for mandatory training.
- Ensure that handovers take place consistently in medical care when transferring patients between wards and departments. The trust should ensure that assessments were carried out promptly by doctors following patients being admitted to the medical emergency unit.
- Ensure that there are clear pathways in medical care, including staffing levels, regarding the care of patients who require non-invasive ventilation (NIV).
- Improve the number of staff on surgical wards who have completed all their mandatory training in line with the hospital target.
- Improve access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Improve the response times to patients' complaints within surgery.
- Improve the timely completion of discharge letters to GP's, including reducing the large backlog of letters which have not been sent within surgery.
- Ensure all staff in critical care are compliant with mandatory training, role essential training and current assessment of staff's paediatric competencies (nursing and emergency procedures).
- Ensure there are adequate allocated hours from allied healthcare professionals to meet national recommendations.
- Ensure there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff in areas where children are cared for in line with national guidance.
- Ensure all staff involved with the care of children are up-to-date with paediatric basic life support and mandatory training.
- Ensure medical and dental staff in outpatients and diagnostic imaging have received training in level two safeguarding vulnerable adults
- Ensure medical and dental staff in outpatients and diagnostic imaging are up to date with mandatory training, including adult basic life support, fire training and paediatric life support
- Improve the rates of mandatory training within the urgent care centre to bring compliance levels in line with the trust's target.

In addition the trust should:

- Ensure that there are suitable quantities of cardiac monitors and trolleys in the emergency department to ensure safe patient careat times of crowding.
- Ensure the provision of specialist support to patients attending the emergency department who misuse alcohol or substances.
- Ensure that the executive team is more engaged with staff in the emergency department and plan times of visits better to prevent a negative impact on staff morale.
- Ensure that equipment used for personal care within medical care services is fit for purpose and that staff are able to provide assistance promptly if the patients become unwell while using equipment. This relates to inaccessible showers.
- Ensure that clinical equipment in medical care, such as needles and blades, is stored securely. The trust should ensure the safe storage of medicines, including creams and ointments, at all times. This should include ensuring that medicines aree stored following manufacturers' guidelines.
- Ensure that where oxygen cylinders are stored in medical care, there is appropriate signage to inform staff and visitors to the area.
- Ensure that staff working in all departments in medical care have access to emergency equipment and medicines in order to be able to respond promptly to medical emergencies.
- Ensure within medical care that care documentation, including care plans, pain and risk assessments were completed in sufficient detail to inform staff of the individualised care and treatment that was required for each patient.
- Ensure that nursing staffing levels in medical care consistently meet the assessed and agreed staffing establishment for all wards and departments.

Summary of findings

- Esure that within medical care performance against national audits is improved.
- The trust should ensure that within medical care the patient's confidentiality was consistently respected when requiring assistance with interpretation and/or translation.
- Ensure that within medical care the complaints process was followed in a timely way and in accordance with the trust policy and procedure.
- Ensure that staff within medical care are consistently informed and knowledgeable about the risk registers for their wards and departments.
- Improve completion of NEWS within surgery.
- Ensure fabric curtains are replaced by disposable curtains to meet national standards.
- The critical care service should ensure processes to monitor and audit compliance with cleaning processes in critical care.
- Ensure effective processes to learn from mortality and morbidity meetings in critical care.
- Ensure staff in critical care check essential equipment daily in line with policy.
- Ensure that in critical care, patients' allergies are always documented and that staff sign for all medicines they administer.
- Ensure the safe storage of medical gasses.
- Ensure all patient medical records in critical care are stored securely.
- The critical care service should ensure practice guidance is regularly reviewed and updated.
- Continue to support the clinical nurse educator role in critical care to comply with national recommendations.
- Review the training and competency assessment of medical staff in critical care to ensure there is always staff on duty who are competent in airway management.
- Explore the improvement of the patient bathroom facilities in critical care to include shower facilities so that these facilities are not shared with relatives.
- Review the arrangements for the provision of follow-up clinics in critical care to ensure these are sustainable.
- Ensure staff have access to appropriate equipment necessary in children's services to carry out their roles and provide care effectively and efficiently.
- Ensure all staff involved in the care and assessment of children and young people have safeguarding training in line with intercollegiate guidance.
- Ensure that systems are in place to ensure case conference notes of vulnerable children are filed in their records in a timely manner.
- Consider the wellbeing of staff within children's and young people's services in terms of regular access to rest breaks and hydration.
- Consider mechanisms which could improve the connection of, and communication between, front line staff and divisional leaders within children's and young people's services.
- Consider options for improving the connection between the Women and Children's division and the rest of the trust, together with considering the representation of children's services at board level.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.
- Ensure that departments within outpatients have access to resuscitation equipment in line with hospital policy
- Provide leaflets within departments in outpatients and diagnostic imaging that are available in different languages.
- Ensure access for bariatric patients in outpatients is improved so they can be assessed and treated without compromising their privacy.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise possible risk and harm caused to patients through excessive waits on outpatient appointments and excessive waits on the reporting of images.
- Make improvements on the backlog in typing time times in outpatients and the delay in letters being sent to GPs.
- Ensure arrangements are in place to replace aging diagnostic imaging equipment identified at risk of failure
- Improve the storage of medicines within the urgent care centre and ensure that medicines are checked and managed by staff.
- Improve the quality of records audits in the urgent care centre to ensure that maximum learning is taken from them.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Great Western Hospitals NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust provides a number of services across a wide geographical area covering Wiltshire, parts of Bath and North East Somerset, parts of Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire covering a population of 1,300,000 people with acute services provided at the Great Western hospital, Swindon. The hospital was built under the Private Finance Initiative at a cost of £148million and opened in 2002. The trust became a foundation trust in 2008.

Wiltshire Local Authority is in the 40% least deprived areas in the country. Of the population 19.0% are under 16 (equal to the percentage in England). The percentage of people aged 65 and over is 19.5% (higher than the England figure of 17.3%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3.6%) when compared to the England figure (14.6%).

We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected the following six core services, some in part at the Great Western Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Services for children's and young people
- Outpatients and diagnostic imaging

We also inspected community services and looked at:

Urgent Care Services

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart, invited independent chair.

Head of Hospital Inspections: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: An emergency department nurse, two junior doctors with experience of working in dent an emergency department, a matron with experience of working in medicine, a medical doctor, a theatre nurse, a surgery matron, a consultant surgeon, a critical care consultant, a critical care nurse, a paediatric consultant, a paediatric nurse, two outpatients nurses, a board level director, a pharmacist, a clinical fellow and an expert by experience.

How we carried out this inspection

We carried out the announced part of our inspection between 21 and 23 March 2017 and an unannounced inspection at Great Western Hospitals Hospital on 27 and 28 March 2017 and 3 April 2017.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and NHS Improvement.

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

Summary of findings

What people who use the trust's services say

The trust's Friends and Family Test performance (percentage recommended) was similar to or slightly worse than the England average between January and December 2016. In December 2016, trust performance was 95.5% compared to the England average of 95.2 %.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for seven of the 34 questions, in the middle 60% for 22 questions and in the bottom 20% for five questions.

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to cleanliness, food, privacy/dignity/wellbeing and facilities. The trust's result for privacy, dignity and wellbeing deteriorated from 92% in 2015 to 86% in 2016, bringing it into line with the England average (84% in both years).

In the CQC Inpatient Survey 2015, the trust performed "worse than" other trusts in two of the 12 questions examined by the CQC and "about the same" as other trusts for the remaining nine questions. There were no questions where the trust performed better than other trusts.

Facts and data about this trust

The Great Western Hospitals NHS Foundation trust provides acute hospital services at the Great Western Hospital which has a total of 494 beds (including 12 critical care beds and 30 maternity beds). Since October 2016 it also provides community health services in Swindon. These services include community nursing teams, therapists and children's and young people's services and an urgent care centre. The trust employs 4,329.6 whole time equivalent (WTE) staff (as of December 2016).

Between November 2015 and October 2016 there were a total of 79,712 inpatient admissions including day cases, 477,452 outpatients' attendances (both new and follow-up) and 125,661 attendances at the emergency department (this had increased from 78,519 emergency department attendances between July 2014 and June 2015).

In the financial year, 2015/16, the trust had an income of £310.4 million, and costs of £320.2 million, meaning it had a deficit of £9.7 million for the year. The trust predicts that it will have a surplus of £44,362 in 2016/17.

Bed occupancy was consistently above 90%, with occupancy 94% during quarter 2 in 2016/17. This was above the England average (87.5%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The executive team and non-executive team were stable, with one new non-executive joining the trust.

CQC inspection history

Since registering with CQC, there had been a total of 11 inspections covering a total of 16 outcomes. A comprehensive inspection of the trust was last carried out in September 2015. At this inspection, significant concerns were identified within the emergency department and in relation to governance processes and a section 29A warning notice was issued. A follow up inspection in April 2016 found that progress had been made but the requirements of the warning notice had not been fully met. A further inspection was carried out in October 2016 when the requirements of the warning notice were found to be fully met.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as requires improvement because:** • Capacity issues presented safety concerns in some areas. The emergency department was consistently crowded, with all cubicles full and patients cared for in the corridor around the nurses' station. Due to the demand for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients. • Medicines were not always managed safely. Daily checks in the emergency department to ensure that medicines and equipment were safe to use were not always completed in line with trust policy. In medical care and critical care clinical areas where medicines were stored were not monitored to ensure the temperature did not exceed the recommended limits. • In medical care some areas where medicines were stored did not have shelving to enable staff to manage effective stock rotation. Oxygen was stored in areas where there was not clear signage in place to alert visitors to the area. • Mandatory training throughout the trust required improvement. Medical staff in the emergency department did not meet trust targets for any of their 10 mandatory training modules. Staff within medical care, critical care, services for children and young people and surgery, were not meeting the trust target for their mandatory training, including safeguarding. Junior medical staff in critical care were not all 'airway competent' with skills in advanced airway techniques. • Within the trust staffing levels and mix were planned and reviewed in line with best practice tools and guidance. In some areas staffing levels and skill mix did not always keep people safe. On wards staffing levels were established against acuity requirements for patients. However, due to high vacancies this was difficult to achieve. • Actual staffing levels compared to planned levels were mixed within the trust. In the emergency department and on medical wards fill rates by substantive staff were mixed which meant a high use of bank and agency staff. The emergency department observation unit was not sufficiently staffed to consistently meet people's needs. Staff at times were lone working in the ambulatory care department. In critical care there was only one junior doctor in the unit at night, when standards recommended a unit of this size should be covered by two at all	**Requires improvement** 

times. Nursing staffing levels did not consistently meet recommended levels on the children's unit or the special care baby unit. Despite a higher use of bank and agency staff patients were kept safe at all times.

- Out of hours medical cover in services for children and young people was shared with numerous other areas of the hospital which meant the service did not always have the medical capacity it needed to care for children as per recommended levels.
- There was a lack of some basic equipment available to nurses on the children's unit, for example thermometers and tape. Not all equipment was maintained in accordance with guidance, for example heated water blankets did not have expiry dates or water change dates recorded.
- In medical care not all documentation relating to patient care and treatment was completed in full. This meant that staff were not fully informed of the action they were to take to meet the patients care and treatment needs. We also found that patients' personal and confidential information was not always stored securely.
- Staff were not consistently provided with a full handover for all patients transferring between wards and departments.
- There was a risk to patient safety post-operatively because of the closure of one of the theatre recovery areas in periods of escalation, which led to a longer route from theatre to recovery
- There were some very long delays over a number of months, in issuing electronic discharge summaries from the surgical assessment unit.
- Patients in critical care were not provided with a rehabilitation 'prescription' when they left the unit.
- Access to resuscitation equipment could be compromised due to the sharing of equipment between departments.

However:

- There was a positive safety culture in all core services inspected. Openness and transparency was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguard them from abuse. All staff understood their responsibilities to identify and report abuse. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.

- In all core services standards of cleanliness and hygiene were well-maintained and minimised the risks to patients from cross-infection. Techniques used ensured cleanliness and infection control measures were in line with National Institute for Health and Care Excellence (NICE) quality standards.
- Medicines, with the exception of some areas, were managed and stored safely. There were audit trails to monitor the use of controlled drugs. Contrast and controlled medications were stored in locked cupboards and fridges. Fridge temperatures were checked daily.
- In all core services records were written and managed in a manner that kept patients safe. Observations, medications, and treatment decisions were made in a timely way.
- The medical care and treatment for patients was provided by sufficient numbers of doctors. Staffing levels in the emergency department had significantly improved since the last comprehensive inspection and there was slightly less reliance on bank or agency staff.
- Handovers took place at the start of each shift to ensure clinicians such as nurses and doctors were aware of the care and treatment needs of each patient.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Staff in all core services consistently had a good understanding of the duty of candour and some were able to give examples of when they had fulfilled the requirements of the Regulation. For example, in medical care following a fall in which the patient had sustained a broken bone, there had been a full investigation and open communication with the patient.
- Most staff in all core services were trained in the practices of duty of candour. Training around the duty of candour was mandatory and was included in the induction for all staff.
- Staff were consistently able to demonstrate to inspectors the importance of being open and honest with patients and apologising to them when something goes wrong, even when the requirements of the duty of candour are not met. We saw examples during our inspection of good clinical engagement with patients and were also informed that clinicians would offer to meet with families when things had gone wrong.

- We reviewed examples of incident reports in all core services where patients had suffered moderate or serious harm and found evidence that duty of candour had been followed. We also found that investigation reports were shared with patients and their families for transparency.

Safeguarding

- There were safeguarding systems processes and practices in place for adults and children, to keep people safe from harm. These were embedded into practices throughout the core services. For example: in the emergency department safeguarding questions were asked as part of a triage checklist and covered topics such as non-accidental injury. In medical care there were robust processes for domestic violence. There were also processes and practices throughout the core services for identifying and supporting patients living with female genital mutilation.
- All policies and procedures were accessible through the trust's intranet. Policies such as the trust's safeguarding adults at risk strategy and safeguarding adult's policies were in line with relevant legislation; for example, The Care Act, (2014) and the Mental Capacity Act (2005), and developed in partnership with the Local Safeguarding Adults Board. In urgent care services the adults safeguarding policy was being reviewed.
- There were notice boards in all departments and wards for staff to use as a resource on safeguarding contacts and processes. In addition, some core services had link nurses for safeguarding who shared the latest updates from the safeguarding team.
- The trust had established a central point for referring safeguarding issues and to access support. This aligned process allowed for quality assurance of safeguarding referrals to take place without delaying the process of raising a safeguarding issue with the appropriate local authority.
- Staff in all core services were aware of their safeguarding responsibilities and knew the processes to follow in the event of a safeguarding concern being identified. All the staff we spoke with were able to talk through the process of reporting a safeguarding concern, and could show us where to find help and guidance to support them.
- Training around safeguarding adults was delivered as part of mandatory training with additional ad hoc training available in some core services. However, compliance rates were mixed within the trust , varied between core services and was better for nurses than it was for medical staff. Some areas performed significantly worse than the trust's 80% target. For example,

medical staff in the emergency department, surgery and outpatients and diagnostic imaging. Also nursing staff in medical care and urgent care services had lower compliance levels than the trust target.

- Training around safeguarding children was also delivered as part of mandatory training with additional ad hoc training and supervision available in some core services. Most areas were in line with the trust's targets for level one, two and three training. For example: in outpatients and diagnostic imaging all staff were appropriately trained. However, we found in services for children and young people that there were not always staff with the correct safeguarding training levels on duty as identified by the intercollegiate document requirements. We also found in critical care that although children were admitted onto the ward, no one was trained to level three in safeguarding children.

Medicines management

- There was an integrated and inclusive approach to medicines management between the pharmacy team and other clinical staff in the trust. Pharmacists were considered where new processes were implemented from an early stage.
- The chief pharmacist had only been substantively in post for two weeks prior to our inspection, although had worked at the trust on an interim basis in the previous year. Already they had a clear idea of the areas for development in the trust and some plans in place to address these. There was good oversight of areas of risk within medicines management, for example: missed doses, medicines optimisation and incidents.
- There was a hospital pharmacy transformation programme and board. The board was chaired by the medical director which provided trust board level support and engagement. The programme plan was linked to trust priorities and quality indicators.
- Medicines incidents were reported monthly to the divisions and reported to the medicines safety group for discussion and action.
- There was dedicated pharmacist time for medicines optimisation with 70% of the time allocated and a target to reach 80%. Each ward in the hospital had a dedicated pharmacist although, time spent depended on the resource allocation from the department or division.
- Work was to be done on improving the compliance with the time taken to complete medicines reconciliation for patients being admitted to the hospital. At the time of our inspection

only 57% were completed within 24 hours against a target of 80%. The chief pharmacist had clear awareness of this and the barriers to achieving this, one being the lack of a seven day service.

- The trust had an electronic prescribing and administration record system. This was implemented in all areas of the hospital with the exception of the emergency department and coronary care, also intravenous infusions were not prescribed or recorded using this system. There was testing ongoing for the use of the system for intravenous infusions.
- There was good antimicrobial stewardship within the trust, given the small size of the team. A business case to increase the pharmacy staff time for antimicrobial stewardship was in the process of being approved at the time of our inspection. There were dosage cards made available to assist staff prescribing some key antibiotics where specific doses were required for a patient's height and weight.

Incidents

- Staff in all core services understood their responsibility to raise concerns, to record safety incidents, concerns and near misses. These were always reported internally and externally as necessary. All staff were encouraged to report incidents through the electronic reporting system and received feedback from them.
- When things went wrong, thorough and robust reviews were carried out. We reviewed a number of serious incidents and never events investigations and found that all (apart from one in urgent care) had been properly investigated and recommendations completed and reviewed.
- Mortality and morbidity was reviewed by the trust. There were service level meetings which discussed learning which then fed into the trust's mortality group. Deaths were fully investigated and learning was shared across the trust cascaded through these service level meetings.

Staffing

- Within the trust staffing mix was planned and reviewed in line with best practice tools and guidance. For example, in medical care and surgical services the safer nursing care tool was used and was reviewed twice a year. In services for children and young people staffing levels were assessed and planned using the Royal College of Paediatric and Child Health guidelines.
- In some areas staffing levels and skill mix did not always keep people safe. On wards staffing levels were established against acuity requirements for patients. However, due to high

vacancies this was difficult to achieve. On one surgical ward, in a three month period only 75% of shifts could be filled with substantive staff. Also, the emergency department observation unit was understaffed which meant that duties regularly took nurses away from patient care.

- Actual staffing levels compared to planned levels were mixed within the trust. In the emergency department and on medical wards fill rates by substantive staff were mixed which meant a high use of bank and agency staff. On some occasions 50% of staff were agency in the emergency department and 20% of staff were agency on the wards. The diagnostic imaging department also relied heavily on bank and agency staff to maintain safety for patients.
- Despite a higher use of bank and agency staff, patients were kept safe at all times. In all areas bank and agency staff had an induction and received training specific for the work they were carrying out.
- Within medical staffing the vacancy rate was mixed. Within the emergency department, surgery, medical care, services for children and young people and critical care medical staffing levels met recommendations to keep patients safe. However, in outpatients and diagnostic imaging there were high registrar vacancies. Turnover rates and sickness rates for medical staff were low.

Are services at this trust effective?

Good

We rated effective as good because:

- The unscheduled care division participated in a programme of local and national audits. Some areas required improvements to meet the national average. For example: the national stroke audit, the national MINAP (heart attack) audit and the national heart failure audit.
- Patients did not always receive they care they required seven days a week. For example, rehabilitation therapy at the weekends.
- The electronic prescribing and medication administration system was reliant on using the hospital's Wi-Fi system and it could take up to 15 minutes to access the system, leading to delays in providing pain relief for patients.
- Provision for therapy services did not meet national standards. There was insufficient physiotherapy and dietitian support and limited support from other therapies.
- Only 45% of non-clinical staff had received an appraisal in outpatients and diagnostic imaging.

- The diagnostic imaging service did not always ensure that it met best practice for time taken to report on images.

However:

- Patients' care and treatment in the emergency department was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. We saw good use of National Institute for Health and Care Excellence (NICE) guidelines. We found that national hip fracture audit results had improved since the last inspection. There was an effective service to assess and provide timely treatment for patients admitted with sepsis or acute kidney injury.
- Information about people's care and treatment was routinely monitored in all core services and action was taken to improve the effectiveness of treatment where shortfalls had been identified. The service monitored patient outcomes in critical care and these were good when compared nationally and to other similar units.
- The nutritional and hydration needs of patients were assessed and actions put into place to ensure they were met. The trauma unit had used innovative ideas to improve nutrition and hydration for patients.
- In surgery, patients had a lower than expected risk of re-admission at the hospital when compared to the national average.
- Staff in all core services had the skills required to carry out their roles effectively. Appraisal, individual supervision and clinical supervision were used effectively to support staff. There were experienced nursing and medical staff who were supported with training and personal development.
- Multidisciplinary working throughout the hospital worked effectively to assess, plan and deliver care and treatment. Multidisciplinary team working was apparent between wards and departments.
- Patients' consent to care and treatment was sought in line with national legislation and guidance.
- Seven-day cover was provided by physiotherapy, pharmacy, mental health liaison and key diagnostic service. The service provided 24-hour outreach to the rest of the hospital seven days a week.
- Improvements had been made in the availability of records with 96.4% of notes being available at the start of clinic and 99.4% by the end of clinic.

Evidence based care and treatment

Summary of findings

- Treatment in the emergency department, medical care, surgery, critical care and outpatients and diagnostic imaging was line with current evidence-based guidance, standards, best practice and legislation. For example, in the emergency department the Royal College of Emergency Medicine's Clinical Standards for Emergency Departments was used. Another example in medical care was that the National Institute for Health and Care Excellence guidelines for chest pain, sepsis and management of aggression were used. In surgical services staff were following guidance set by the RoyalCCollege of Anaesthetists and Royal college of Nursing, for example, anaphylaxis audits and falls and fragility audits.
- In critical care we found that although evidence-based care and treatment was being delivered. The folders which stored policies were not always dated to ensure up to date guidance was within them. We also found that National Institute for Health and Care Excellence guidelines for rehabilitation were not always being followed.
- We found that in urgent care services policies and protocols were sometimes out of date. This meant that processes may not be in line with the latest evidence-based practice. We also found in medicine that not all National Institute for Health and Care Excellence guidelines for stroke management were in place. In surgical services we found that the sepsis pathway was not always delivered in a timely way.

Patient outcomes

- Information about the outcomes of patients care and treatment was routinely collected and monitored. In the emergency department the trust took part in the Royal College of Emergency Medicine national audits. Medical care took part in various national audits including the national sentinel stroke audit. The service scored the highest grade (of A) for both patient and team-centred performance and showed improvement in all other measures. In critical care the service submitted data to ICNARC.
- Surgical services took part in many national audits, such as the bowel cancer audit, oesophago-gastric cancer audit and the national emergency laparotomy audit. 90 day post-operative mortality for these audits was within the expected ranges and showed improvement since the last inspection. The national hip fracture audit had a mortality rate which was worse than the national average, but showed improvement since the last inspection. In critical care mortality rates were in line with national averages.

Summary of findings

- We found that urgent care services did not collect patient outcomes. However, a programme of audit was being created at the time of the inspection.

Multidisciplinary working

- Care was delivered in a coordinated way in all services we inspected. In medical care we observed several multidisciplinary ward rounds and multidisciplinary meetings which enabled multiple staff groups to discuss a patient's treatment. In surgery daily huddle meetings and in critical care morning rounds took place which provided an opportunity for multidisciplinary working to assess patient needs and treatments.
- A critical care outreach service was available for all wards. This provided 24 hour seven days a week service and received referrals via telephone. In the three months prior to the inspection the outreach team had seen 171 patients and also followed up patients that had been discharged from the intensive care unit to wards. When required the outreach team was able to assess patients in the emergency department.
- In the emergency department the managers felt that medical and surgical specialities were taking more responsibility for their patients. Plans were in place to further integrate the emergency department and urgent care services to promote more effective care for patients requiring emergency services.
- Mental health liaison services and diagnostic imaging services were available seven days a week who responded quickly to referrals. Adult pharmacy services were available seven days a week. However, there was no specific paediatric advice available out of hours.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients' consent to care and treatment was sought in line with legislation, guidance and best practice. Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- The trust provided training on consent and mental capacity with a trust target of 80%. Nursing staff in all services were above this target with the exception of from critical care, where the completion rate was 69%. Training completion rates for medical staff in the emergency department and surgical services were below the trust target.

Summary of findings

Are services at this trust caring?

Good

We rated caring as good because:

- In all core services feedback from patients and their relatives was consistently positive about the way staff treated them. People were mostly treated with dignity, respect and kindness, regardless of how busy they were. In the emergency department care was consistently of a high standard despite the amount of pressure staff were under.
- We observed many occasions where staff responded compassionately when patients needed them to. Staff were kind, caring, supportive and helpful towards patients.
- Staff told us about an example of where they had 'gone the extra mile' to provide compassionate care to support a patient who was at the end of their life to get married in the emergency department. Staff told us how they had made sure that this was a special experience for the couple.
- Relatives we spoke with told us they felt informed and were involved in decisions about the care of their loved ones. Staff communicated with patients in a way that they could understand and worked with patients to ensure there was a shared decision-making process.
- We saw an example of a member of staff helping a patient to cope emotionally during a traumatic situation within the emergency department. Staff understood the social needs of patients and adapted their care accordingly.
- The privacy and dignity of patients was respected and promoted in most areas throughout the hospital.

However:

- The privacy and dignity of patients could be compromised in certain parts of the hospital. In the discharge lounge the dignity of patients requiring personal care could be compromised. Some patients' dignity was compromised by a lack of toilet facilities in the surgical assessment unit and theatre recovery. Patient assessments and conversations could be overheard in the ophthalmology department.

Compassionate care

- Staff understood and respected patients' personal, cultural, social, and religious needs and took them into account when communicating with them. In all core services there were examples of compassion being displayed towards patients with conversations being tailored to fit their needs. Examples included staff altering communication styles when talking with children in the emergency department.

- Communication between staff, patients, and those close to them was considerate and respectful. An example was in surgery where a patient who was having a local anaesthetic was put at ease by staff and was treated with dignity and respect. In medical services staff took time to get to know their patients well and we found that preferred names were being used.
- Staff showed an encouraging, sensitive and supportive attitude towards patients and those close to them. In medical care patients commented that "nothing was too much trouble" for the staff and that they were going out of their way to help them. In the emergency department patients regularly commented that staff took time to talk with them and care for them properly.
- People's privacy and dignity was respected throughout most of the hospital when having confidential conversations and intimate examinations. In outpatients and diagnostic imaging confidentiality was respected and processes were in place to ensure conversations were not interrupted. However, we found that the design of some facilities in the emergency department, outpatients and diagnostic imaging, and the urgent care centre did not promote privacy and confidentiality. Patient conversations could sometimes be overheard.

Understanding and involvement of patients and those close to them

- Staff in all core services communicated with people so that they understood their care, treatment and condition. For example, in medical care patients were given time to ask questions about their treatment so that they were fully informed. Another example in surgery was patients told inspectors they had things explained to them in different ways to help them understand.
- Staff recognised when patients and those close to them needed additional support to understand treatments and be involved in their care. For example, in outpatients and diagnostic imaging, as well as translation services, additional tools were available to support communication with patients with visual or hearing impairments.
- In all core services staff directed and supported patients and those close to them to find and understand relevant information. For example, in medical care patients using the heart function service were put at ease as a result of quality information being given and explained to patients.

Summary of findings

- Patients and those close to them were routinely involved in planning and making decisions about their care and treatment in all core services inspected. For example, in emergency care relatives we spoke with felt included as part of conversations and understood treatment and care that was being given.

Emotional support

- Staff we spoke with in all core services understood the impact that patients' illnesses and injuries had on their wellbeing, both emotionally and socially. For example, staff in outpatients and diagnostic imaging could describe examples of and showed us letters where the quality of conversation impacted positively on a patient's wellbeing. One patient said that the staff were caring and supportive and that this made the ordeal easier to deal with.
- Patients and people close to them were given appropriate and timely support and information to cope emotionally with their care, treatment, or condition. There was a chaplaincy service available for all patients and people close to them. This provided spiritual support for anyone requiring it. Staff in critical care promoted this service to their patients and their relatives.
- In medical care patients on elderly care wards had access to manicure and hand massage sessions. Staff described how this helped patients emotionally to cope with being an inpatient and was particularly relaxing for patients living with dementia. Staff in surgery also described access to a psychiatric liaison nurse who could support the wellbeing of patients.

Are services at this trust responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patient access was a challenge, particularly into the emergency department, where increasing patient attendances and challenges with patient flow through and out of the hospital having an impact on this.
- Flow also had an effect on the surgical service where the most commonly reported reason that surgery was cancelled was because of bed shortages.
- Not all cancer standards were met by the trust.Urgent GP cancer referralsg were not always seen within two weeks. Performance was below the two week standard was for three out of the past ten months.

- Surgical referral to treatment time standards were worse than the England average in five specialities (urology, ophthalmology, ear, nose and throat, oral surgery, and trauma and orthopaedics).
- Space within the hospital was challenging, for example, the size of the emergency department was not adequate for the volume of patients who attended.

However:

- The trust had clear oversight of the challenges to flow within the hospital and had taken action to rectify these. Services such as "home to assess" had had an impact on the numbers of discharges, but the low availability of community beds and domiciliary care placements had a significant impact on the traction of these actions.
- The trust's referral to treatment time (RTT) for admitted pathways for medicine had been better than the England overall performance.
- The trust achieved above the national operational standard, 96%, for people waiting less than 31 days from diagnosis of cancer to first definitive treatment; as well as being above the national operational standard 85% for people waiting less than 62 days from urgent GP referral to first definitive treatment.
- There were systems in place for the management and monitoring of complaints and to ensure that patients received a response in a timely manner. There was a reporting structure, monitoring and management system in place. There was substantial assurance of learning from complaints, although not all complaints were responded to in an empathetic manner.

Service planning and delivery to meet the needs of local people

- The hospital opened in 2002 and did not have sufficient space to meet the needs of the population as it had grown significantly larger in the 15 years since opening. The trust were keenly aware of this and were working with the PFI provider and commissioners to utilise the buildings and surrounding space as effectively as possible in the short, medium and long term to meet the needs of the growing population of Swindon. However, the challenges were evident at the time of our inspection.
- The size of the emergency department was not adequate for the volume of patients who attended. During this inspection queuing in the corridor was a regular and common occurrence and at all times there were patients in this area. There were no curtains or blinds in this area which resulted in privacy and

dignity being compromised. We saw at times that observations were taken and recorded in this area and blood tests were taken. At times of crowding, two patients were placed in some of the cubicles at the same time to free up space in the corridor and trolleys were placed alongside each other.

- Medical services had gone some way to improving patient flow within the emergency department. The ambulatory care service had become bigger which meant that more patients were streamed away from the emergency department. A medical expected unit had opened two weeks prior to our inspection. The unit enabled GPs to directly refer patients for assessment, care and treatment without the need for them to attend the emergency department. The full impact of this could not be assessed during the inspection.
- In surgical services many surgical areas were being used for medical patients. This had an impact on the number of elective operations that could be undertaken. The day case unit, surgical assessment unit, and recovery areas within theatres were all used for medical patients during periods of escalation.
- The day surgery unit was equipped for eight patients, but incident reporting showed that on occasion up to 20 patients were placed on the unit. This had led to staff shortages, and single sex breaches. Further investigation identified that there had been seven weeks where breaches had occurred, and in one week there had been 50 breaches.
- The use of technology within the diagnostic imaging department to meet the needs of patients had recently won an award. The department had won the British Medical Association award for Patient Information in 2016 for the use of videos to show what patients can expect from an MRI scanner. Patients could find the video on line via a hyperlink that was sent prior to their appointment.
- The trust was also working with partners within Swindon to develop an accountable care organisation in order to better meet the needs of the local population for their health and social care needs.

Meeting people's individual needs

- A learning disabilities forum met four times a year and invited patients living with a learning disability to attend. Feedback was gained from this forum and an action plan was in place to improve services for this patient group. Actions from this had included a hospital passport and raising awareness of making adjustments to support patients with learning disabilities.

- Training in learning disabilities made up part of the trust's safeguarding level one training which all staff should attend. For most core services training for level one safeguarding was above the trust's target of 80%.

Dementia

- The trust considered the management of patients living with dementia and had made changes to the environment to support these patients further.
- In the emergency department there was a dementia friendly cubicle which was decorated differently to allow patients to find it easier. There were also processes in place to ensure that patients living with dementia had greater oversight from staff in the department.
- In medical care juniper ward had specialised in the management of patients living with dementia. The environment had been carefully considered to support these patients, including changing floors and visual aids. Trials had been done to establish the best eating habits for patients living with dementia which had resulted in them eating more. In surgical services memory boxes were in use to stimulate patients living with dementia.
- Most staff had received dementia awareness training as part of their mandatory training. All staff we spoke with were able to describe to inspectors how they would make reasonable adjustments for patients living with dementia. Every ward and unit had a dementia champion who was a link to the trust's dementia team and charities for support.

Access and flow

- Access and flow was a challenge for the trust and as a result, patients did not always receive care and treatment in a timely way. There was a shortage of beds in the trust which impacted on referral to treatment times for surgery, and caused lengthy delays in the emergency department. However, there was good oversight of the challenges within the organisation through the daily clinical site meeting and engagement of the patient flow team and integrated discharge team.
- The chief operating officer chaired the clinical site meeting where there was a slick presentation of the bed status and of the potential, actual and definite discharges for the day. There was evidence that the “home to assess” process was working and enabled discharges from the hospital. There was clear

evidence that the trust had implemented actions to facilitate patient discharge from the hospital, but that the low availability of community beds and domiciliary care placements had a significant impact on the traction of these actions.

- We observed that the patient flow team had joint ownership and oversight of flow, occupancy and capacity within the trust. The flow dashboard demonstrated the number of patients who were medically fit for discharge (80 patients at the time of our inspection) and this was broken down to ward level for analysis. The dashboard also identified the number of lost bed days, which was at around 800 at the time of our inspection.
- We were told that at the time of our inspection the hospital was running at between 100 and 110% bed occupancy. This was above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The emergency department capacity was significantly impacting on flow throughout the hospital. Data showed that the number of attendances at the emergency department had increased by 60% over a two year period from 78,519 emergency department attendances between July 2014 and June 2015 to 125,661 between November 2015 and October 2016.
- The trust was not meeting constitutional standards in relation to urgent care. In the emergency department patients should be admitted, transferred or discharged within four hours of arrival. Between January and December 2016 the department consistency breached this standard. Between December 2016 and March 2017 the average percentage of patients being seen within four hours was 71%.
- Patients should either be admitted or discharged from the emergency department within 60 minutes of seeing a doctor. Between December 2016 and March 2017 the number of patients whose decision to admit or discharge was made within 60 minutes was 25%. Many patients were in the department for over 12 hours. Between December 2016 and March 2017 5% of patients were in department over 12 hours. Between the same time period 25.3% of patients were in department between four and 11 hours.
- Patient flow issues throughout the hospital contributed to the delays in the emergency department. When looking at the causes of the breaches of targets within the department, the majority of these had been due to the lack of medical beds (60% of breaches) or surgical beds (5% of breaches) within the hospital.

Summary of findings

- Within surgery, bed shortages across the hospital were identified as the most significant factor in surgery cancellations on the day (39% of total reportable cancellations). The other high contributor was a lack of theatre time (12%), which was also indicative of flow issues between theatre, recovery and the day surgery unit, and wards.
- Patients requiring surgery were regularly not being treated within 18 weeks of referral. Five specialities (urology, ophthalmology, ear, nose and throat, oral surgery, and trauma and orthopaedics) performed worse than the England average. However, general surgery performed better than the England average.
- Patient flow was managed well in critical care. Between March 2016 and March 2017, four patients had a delayed admission. We reviewed four medical records and found patients had been admitted within four hours of referral in line with recommendations form the Faculty of Intensive Care Medicine (FICM, 2015) standard 2.3.
- For medical care patients, between January and December 2016 the trust's referral to treatment time (RTT) for admitted pathways for medicine had been better than the England overall performance. The latest figures for December 2016 showed 94% of this group of patients were treated within 18 weeks versus the England average of 90%.
- Within outpatients, referral to treatment targets stipulate that patients should be treated within 18 weeks of referral. Between January 2016 and December 2016 the trust's referral to treatment time (RTT) for incomplete pathways showed an improvement, with 7 months of the year being above the national target.
- Urgent GP cancer referrals were not always seen within two weeks to ensure timely diagnosis and treatment. The trust was performing below the operational standard of 93% at the time of our inspection with 82.1% being seen as of January 2017, however the trust had been achieving above the standard for seven out of ten months between April 2016 and January 2017. The trust achieved above the national operational standard, 96%, for people waiting less than 31 days from diagnosis to first definitive treatment; as well as being above the national operational standard 85% for people waiting less than 62 days from urgent GP referral to first definitive treatment. At the time of our inspection, it was achieving only 81.8% in January 2017 for cancer screening within 62 days against a national standard of 90%, however it had been above the operational standard for the previous nine month period.

- A contributing factor to the two week cancer referral targets was the access and reporting of diagnostic imaging. The diagnostic imaging service did not always ensure that it met best practice for reporting on images. Data provided by the trust showed that 39% of urgent X-rays were not being reported within the 24 hour time frame. Also 25% of routine X-rays were not being reported within the five day time frame.

Learning from complaints and concerns

- There were systems in place for the management and monitoring of complaints and to ensure that patients received a response in a timely manner. Central to the governance arrangements was the complaints policy which operated within the trust- wide governance infrastructure. The policy the trust provided prior to the inspection was dated 2014 and was due for review in March 2016. There were gaps in the 2014 policy, it did not guide best practice and practice was not following this policy. However, during the inspection a new policy dated March 2017 was produced which followed national best practice guidance and covered all aspects of complaints management. It was very comprehensive and provided all the guidance needed to understand how the trust wanted complaints and concerns handled. There was also clear guidance on the link between complaints and incident management. This was in line with best practice. We found that practice within the trust followed the more recent guidance.
- There was a reporting structure, monitoring and management system in place. Leaflets were available and there was clear information on the website. These were worded in line with best practice, although, very small in size and may be difficult to read for some people. Complaints information on the website was accessible in two clicks which is the national standard.
- Accountability for complaints was devolved to the divisions where there was good ownership and understanding. Each division was supported by a patient advice and liaison service (PALS) officer. Oversight of complaints was via the divisional governance committee which reported to the patients safety and quality committee and then to the trust board.
- Staff were trained in complaints investigation to a good standard and were aware of how to access and use the complaints arrangements.
- Of the six complaint files reviewed three met the 25 day response deadline, and the remaining three were responded to in 38, 71 and 82 working days respectively. All final responses

answered the complainants' concerns. However, only one gave a compassionate and caring apology. The remaining five apologies were dispassionate and didn't obviously show empathy.
- In the new policy there was a clear guide on how learning from complaints was incorporated into local clinical governance plans and monitored by the divisional leadership.
- There was substantial assurance of learning from complaints. This had recently been audited within the trust. Learning was monitored through divisional clinical governance committees and led by the governance leads. There was evidence of patient experience videos and soundbites presented at the trust board.

Are services at this trust well-led?

Good

We rated well-led as good because

- The trust had a clear vision and strategy with the patient, quality, safety and sustainability at the heart of it. Staff were able to articulate this and demonstrated this in their behaviours. The engagement with external stakeholders in securing the sustainability of the service through the acquisition of the community services in Swindon and working towards building an accountable care organisation was good. There had been significant action by the trust as a result of our last inspection, with progress being seen in most areas. Where the pace of progress was slower there were clear plans in place and changes were in train.
- Governance arrangements had been reviewed, developed and were in the process of being embedded since our last inspection. The board assurance framework, committee and sub-committee structure had been updated so as to provide the board with greater assurance.
- Leaders had the skills, knowledge and experience to promote good quality care. They were aware of the challenges and action had and was being taken both internally and externally to resolve these. The board was relatively stable although there had been new non-executives appointed since our last inspection.
- There was good patient engagement within the trust, with some being engaged in developing services.
- Staff engagement was good in most areas of the trust, although the executive team was not seen as being as visible as they could be. The trust was aware of this and was working to improve this.

Summary of findings

- The financial position had improved since our last inspection, although was still challenging and under scrutiny. Action had been taken so as to ensure that this did not impact upon the quality and safety of care and treatment provided to patients.
- Innovation was ongoing in the trust, notably within staff development and also in the theatre utilisation work.

However:

- Not all areas of the trust were fully engaged. Services for children and young people were isolated from the rest of the organisation.
- There was limited visibility of the quality and depth of challenge and assurance provided at board within minutes. This proved challenging for commissioners in their ability to gain their assurance of the quality of services provide and assess the board's level of assurance.
- There was no board development programme in place.

Leadership and culture of the trust

- Leaders in the trust had the skills, knowledge, experience and integrity needed to promote good quality care. The executive team was stable and had a mix of experienced and developing directors, all of whom had the skills and knowledge to undertake their roles.
- New non-executive directors had been appointed since our last inspection, although the majority remained constant. This had brought additional depth of experience, notably clinical.. All had suitable skills, knowledge and experience to provide challenge to the board. There was awareness of the potential for non-executives to become engaged in the operational leadership of the organisation and the chair and chief executive ensured that this did not happen.
- The chief executive had built a team which had the capacity and capability to lead the trust effectively. All of the executive team were substantively employed by the trust with the exception of the chief operating officer, who had been engaged on a long term interim basis. This interim appointment provided someone with proven experience of managing and leading in other organisations who had similar challenges. The work carried out by the chief operating officer in conjunction with other executives, also provided a basis for the future development of the organisation.
- There was a programme of board seminars within the organisation, but no clear board or organisational development programme.

- The board understood the challenges to providing good quality care within the trust and had taken action to address them. This to the most part had proved successful, but the challenges to access to services and to flow across the system continued to have an impact upon the trust, despite actions taken. These included the increasing population and the significant vacancies within GP practices across the patch. The trust was working with partners to look to shape services in the long term to improve on these issues, as well as acting internally to improve on the safety and responsiveness of the service.
- We were told by staff across the trust that senior leaders were not as visible as they could be. This was notable in services for children and young people, where staff felt "missed out" when executive and non-executive walkabouts occurred. Although staff in the emergency department noted that executives did visit the department, it was felt that this was during times of crisis rather than when things were working well. The executive team was aware of this, and had implemented: safety visits and ad hoc walkabouts; executive led open forums throughout the year; regular site communication; and monthly senior nurse clinical days, although the impact of these was not yet seen.
- The culture within the trust was centred around the needs and experience of patients and flowed from the values, vision and strategy for the trust. There was a culture of openness, with all staff and leaders within the trust employing a transparent approach.
- In most areas of the trust there was a focus on staff wellbeing, which had improved since our last inspection. This was notable in the emergency department, where, although staff were still working in extremely challenging circumstances, morale had improved. However, staff within services for children and young people felt disconnected from the organisation and there were limited formal opportunities for leaders (particularly within the special care baby unit) to be assured of the wellbeing of staff.

Vision and strategy

- The trust had a clear vision, with the patient, quality, safety and sustainability at the heart of it. This was the trust's 2020 Vision and focused on working with partners to deliver accessible, personalised and integrated services for local people, at home, in the community or in hospital. The empowerment of people and prompting independence and healthier lives was integral to the vision.
- Underpinning the vision were strategies for: quality, infrastructure, people (human resources) the long term financial model of the organisation and a clinical strategy.

These were all focused around the patient. These had been badged as providing the best service and best care. These all fed into the trust integrated business plan which encompassed the NHS Improvement Annual Operations Plan and the organisational business planning. The strategic priorities and key objectives were developed with input from staff and set and agreed by the trust board.

- There had been significant action by the trust as a result of our last inspection, with progress being seen in most areas. Where the pace of progress was slower there were clear plans in place and changes were in train.
- The trust, in 2015 set a safety goal to save an extra 500 lives by 2020, through providing consistently safe and high-quality care. Ongoing improvements were focused around the trust's five sign up to safety priorities as well as a range of other projects. This involved adopting best practice, using internationally recognised tools and learning from mistakes.
- The vision and strategy was evident throughout the divisions in the trust.
- Work was ongoing to incorporate the community services acquired by the trust in October 2016 (as caretaker for the services) and in April 2017 permanently. The trust was working with the local authority to develop a long term strategy to have an integrated accountable care organisation, for health and social care in Swindon.
- The strategies in place were realistic for achieving the priorities of the organisation and to delivering good quality care. The significant challenges in the health economy within both primary and community services were acknowledged and the strategies within the trust were not only internally focused but also looked to help drive improvement externally through the accountable care organisation.
- There were a clear set of values in the organisation: service; teamwork; ambition; respect (STAR). These were seen as integral to achieving the trust vision and were the expected ways to work and treat each other. This was evident throughout the trust.
- Visions values and strategies within the divisions of the trust were aligned to those centrally and staff throughout the organisation were aware and could articulate them.

Governance, risk management and quality measurement

- The governance arrangements in the trust had been strengthened since our last inspection. A full review of governance arrangements had been undertaken. This included a review and revision of the board and sub-board committee

structure. This detailed review had been undertaken by the company secretary and included amendments to the structure, which included the addition of the performance people and place committee. This was responsible for the oversight, scrutiny and challenge of operational, workforce performance, IT, estates and facilities management. Another notable change was that of the governance committee which had been renamed the quality and governance committee, and had oversight of quality and safer staffing performance alongside the existing governance agenda.

- The new board and sub-board committee structure had been presented to the trust board in October 2016 and implemented from January 2017. Terms of reference for all board and sub-committees had been reviewed and updated accordingly. There was also clarity of the membership of committees and sub-committees along with those executive and non-executive who were expected to attend or invited as necessary. Work plans and standing agendas for the committee and subcommittee meetings throughout the year were also set. A new scheme of delegation had been approved in January 2017 which reflected the changes.
- Alongside the changes in the committee structure, the board assurance framework had been reviewed and updated with a clear link to the risk register. The board assurance framework linked to the CQC domains of safe, effective, caring, responsive and well led. The overview matrix linked to underpinning dashboards of performance data which were clearly risk rated as red, amber or green. Improvements, maintenance or deterioration in performance was also clearly identified on the overview matrix.
- There had been a review of the board assurance framework carried out by internal audit in March 2017. There were no recommendations for improvement.
- An associated risk management strategy had been reviewed, updated and approved in November 2016, along with a refreshed risk tolerance statement in December 2016. Risk management workshops were run at board and divisional level to ensure awareness and the importance of the new risk management strategy and systems. Risk dashboards had been put in place in divisions and departments to focus discussion. There was monthly reporting and monitoring of risk registers, dashboards and risk profile trends had been implemented along with quarterly comparisons in order to identify themes or areas of concern.

- Executive and non-executive directors could articulate the challenge provided at board level. Executives felt that it was robust and appropriately challenging without being aggressive. They felt there was sufficient information presented at board level.
- A quality governance framework had been developed and implemented across the trust to support consistent governance processes. There was clear visibility of risks, performance and monitoring within divisions and at a sub-board level and there was evidence that this was reported to board. As a result there was improved communication from ward to board. However, the visibility of the detail of reporting and challenge at board was not clearly evident within board papers and minutes. Whilst there was a focus on not providing excessive detail at board meetings, this proved a challenge for commissioners in assessing whether the trust board gained and was providing them with assurance or reassurance.
- There was transparency in the publication of board papers and agendas on the trust website. This was automated and ensured swift publication. It also ensured that board members received papers and agendas in a timely manner prior to meetings and were only directed to the attendees.
- There was also work ongoing to integrate the community services which had been acquired in October 2016 into the organisation. The trust had identified a number of risks associated with these services and mitigation was in place. They were also integrating the governance processes with that of the trust.

Equalities and Diversity – including Workforce Race Equality Standard

- Improvements were needed in the equalities and diversity agenda within the trust. There was an equalities and diversity policy which had been reviewed and was awaiting board approval at the time of our inspection. This policy met the requirements of the workforce race equality standard. Both the workforce race equality standard statement and the EDS2 statements were advertised as being on the trust website. However, both were empty templates.
- The trust had identified there were no equalities and diversity issues with its black and minority ethnic (BME) employees and apart from the staff hierarchical data there was no evidence to the contrary. There was no evidence that equalities and diversity is an embedded central policy driver for the trust or that there were specific methods in place for listening to and

engaging with minority groups within the staff. It was not clear who amongst the senior staff is driving the equalities and diversity or the workforce race equality agenda as three directors and the company secretary all named one of the other three as the lead.

- A baseline audit was undertaken in April 2016, based on the trust equalities and diversity arrangements and a rating of limited assurance given by internal audit. Recommendations were made and priorities given to each recommendation. Management actions were recorded and all actions recorded as completed. However, some actions appeared insufficient and lacked clarity, for example: the resource to take the equalities and diversity agenda forward and reporting to board. T
- There was a detailed action tracker in place, monitored by the quarterly equalities and diversity working group. This was last updated March 2017. The majority of the 73 actions were reported as completed, although none were reported as tested or embedded. Four actions (all administrative) related directly to the workforce race equality standard. All were completed. However, there was no evidence of a workforce race equality standard action plan against the nine standard indicators.
- There was an equalities and diversity working group which met quarterly. There were terms of reference, but these were not dated and there was not clarity about the name of the working group. The chief executive was the chair of the meeting, but had not attended the three quarterly meetings prior to our inspection. However, the meeting was always quorate. It was not clear if there were any sub-groups reporting into this group, for example, BME, LGBT or Physical disability groups.
- Minutes of the meeting in January 2017 showed that the workforce race equality standard was on track for submission but there was no evidence of any debate on the workforce race equality standard issues. This was the case in all five sets of minutes examined.
- Trust had identified an existing HR business partner and an information governance officer to lead the equalities and diversity work, as part of their existing role and no additional resource was allocated to meet the equalities and diversity and workforce race equality standard requirements. There was no BME forum, LGBT forum or any other group which looked to or listened to the specific groups who may have a contribution to the equalities and diversity agenda. In 2008 a member of nursing staff started a BME group which had the support of the trust but folded after one year due to lack of attendance.

- A brief update on the equalities and diversity work was presented to the board in December 2016 as part of the quality report update.
- However; the BME staff we spoke with told us that all staff were treated the same, regardless of ethnicity and there were not BME issues negatively affective staff across the organisation. There was limited awareness of the equalities and diversity working group or the workforce race equality standard, but all staff felt able to raise issues with senior managers within the trust. No-one was aware of any bullying or harassment related to BME issues. Although data showed that career progression had a low ceiling, people were supported in their team.
- The trust had started to take action, but there was further work to do to engage staff; deliver the workforce race equality standards and equalities and diversity agenda and to test and embed the changes described within their action tracker.

Fit and Proper Persons

- The trust was meeting their obligations under the fit and proper persons requirements. Since our last inspection the trust had reviewed their arrangements regarding the fit and proper persons requirements in line with our regulations. They had adopted and adapted a toolkit developed by NHS providers, the NHS Confederation and NHS Employers. This set out the process to assure the board that they complied with the fit and proper persons requirements. The toolkit was ratified by the trust board in July 2016.
- Following ratification of the toolkit, the company secretary carried out a review of all directors files to ensure that all relevant documentation was contained, they were clearly organised in a formalised manner.
- Annual declarations were in place for all directors which the trust chair had oversight of and had signed them all off.
- All of the six files reviewed contained all relevant documentation in line with the toolkit and contained declarations signed off by the chair.

Public engagement

- The trust carried out patient surveys across the hospital in addition to the NHS Friends and Family Test. For example within the emergency department the views and experiences of patients who were in the department for longer than 12 hours were gathered and acted upon to share and improve the

service provided. Within services for children and young people, a "parents' pantry" had been created in order to allow parents to prepare their own meals rather than having to visit the hospital café.
- There was a learning disability forum within the trust which met four times a year and included patients living with a learning disability. The forum engaged patients and their families of carers in developments in the hospital and had been key to implementing the hospital passport, which supported patients with a learning disability in sharing information that was pertinent to them and their care.

Staff engagement

- Staff engagement was variable across the trust. The executive team was aware of this and actions were being taken to engage more at a senior level. However, the staff survey showed that there was good staff engagement within the trust.
- There were differing approaches to staff engagement in different areas of the trust. Within surgery there was a quarterly newsletter "surgical snippets" and the staff reported within the staff survey that they were able to contribute to the improvements at work.
- Work was ongoing to engage with and support the staff in the newly acquired community services.
- There was a staff excellence awards and patients' choice awards programme. We reviewed nominations from across the trust which showed that staff, managers and the executive team nominates individual staff members and teams.
- Improvements were required in the staff engagement within services for children and young people. Although staff were engaged and supported within their division, they felt isolated from the rest of the hospital.
- In outpatients staff reported that there were listening events and "you said, we did" events to improve engagement. This allowed staff to voice concerns and to suggest improvements in the service.
- Most wards, departments and divisions had monthly and quarterly meetings and drop in sessions to engage with staff, although it was reported that workload affected attendance.

Innovation, improvement and sustainability

- The trust had taken significant action to improve their financial position. This at our previous inspection was having an impact on the quality and safety of the service. The finance director worked closely with other executives both clinical and non-

clinical to ensure that there was a link between finance and the quality of services provided. There were robust processes and governance for financial management within the trust. There was clinical sign off of cost improvement programmes.

- There was greater ownership of financial matters within divisions in the trust. This was through the empowerment and support of the finance director with key staff within the divisions. Cost improvement programmes were allocated through work streams with an executive lead supporting them. The finance director attended divisional performance meetings on a monthly basis to review and provide support to the divisional leadership teams with their financial monitoring and performance.
- Cash flow had improved within the trust, although was under constant scrutiny. Payment plans had been set up with creditors and although a challenge, was achievable if they kept to plan. Capital expenditure remained a challenge although the trust continued to bid for capital funding. Bids were based primarily on the risk register with all divisions engaged in the process. There was a proactive approach to future cost avoidance in considering managed equipment services which was being reviewed via the trust transformation board.
- There were processes in place to monitor agency provision of staff, with a focus on retaining substantively employed staff in order to reduce the reliance on agency. There were clear authorisation processes.
- The trust had implemented a theatre utilisation program which had identified cost improvements of £0.5million in 2016/17 and an additional £0.5million in 2017/18. This was to be achieved through timely starts to lists, reducing late finishes and increased patient throughput. There were also piloting the practice of undertaking all day theatre lists, using the same theatre team to improve efficiency. This involved amendments to consultants' job plans, but, it was reported to us that consultants were volunteering to work in this way.
- Although there was still a challenging financial position within the organisation, there was a real focus on the learning and development of staff. "Career triangles" had been developed with staff career path and learning in mind. Each career triangle had learning and development identified which would enable a member of staff to progress to the next stage in their career.

Overview of ratings

Our ratings for Great Western Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	☆ Outstanding	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Great Western Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health urgent care services (MIU)	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall Community	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Overview of ratings

Notes

1. We have deviated from the aggregation principles by not aggregating the ratings for (community) urgent care services to the overall trust rating. This is in recognition of the fact that, at the time of our inspection the trust had only been running these services for six months.

2. We have also deviated from our aggregation principles in respect of the provider rating for well led. We have rated the trust good in this domain. This is in recognition of the significant work and improvements made since our last inspection. The trust had strengthened governance arrangements and the trust board had good oversight of quality, safety and the trust's financial position, which had improved. Significant challenges in respect of capacity, access and flow were well understood. The trust was working with partners to address these challenges to ensure future sustainability of healthcare in Swindon.

Outstanding practice and areas for improvement

Outstanding practice

- The work of the education lead in the emergency department to improve education through various initiatives and work steams including improved appraisals, training as part of the governance days and introduction of structured workbooks and teaching sessions.
- The understanding and involvement of patients and those close to them in the paediatric emergency department during observed triages. The nurse put the patient at ease and made sure that the process was explained in a compassionate way.
- The understanding of the emergency department leadership team of performance, governance, risks and its impact on patient care.
- The use of an emergency department monthly governance day to engage staff with governance and learning from incidents, concerns or near misses.
- The use of social media in the emergency department to engage staff to be more engaged with governance, share learning and discuss concerns with senior members of staff.
- The work of the clinical trials team in the emergency department to increase trial recruitment from very few patients a year to several hundred patients a year and the impact this has had on patient experience in the department.
- The medical care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The medical care service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The trauma unit within surgery provided a picture menu which showed photographs of all food options that the hospital provided. This could be used for non-verbal patients or patients with learning disabilities so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.
- The outpatient service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The outpatient service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The monthly staff newsletter in the urgent care centre contained information on departmental news, department performance and updates on policies and procedures.
- The trust had introduced acute neurology clinics, located close to the short stay/ambulatory care unit, for patients who attended the acute medical unit and would have needed to be admitted in the past for further opinions and tests. These patients could now be discharged with an appointment, either the following day or the day after. This initiative had led to a significant number of admissions being avoided and provided a positive experience for patients.
- The cardiology department inserted the first four lead pacemaker for a patient in the world. The medical staff were monitoring the patient's recovery and rehabilitation as part of an international research project to assess the advantages of the new technology.
- A GP was employed in ambulatory care four days a week. The purpose of this new position was to improve communication with GPs to ensure basic tests had been completed prior to the patient attending the ambulatory care unit. It was anticipated that this would help to increase the flow of patients through the department and prevent patients attending the unit unnecessarily.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Ensure that the emergency department observation unit is sufficiently staffed to keep people safe.
- Ensure that medical staff in the emergency department receive appropriate mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that daily checks are conducted on resuscitation equipment and medicine fridges in the emergency department to assess that they are safe to use.
- Continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department as pace to improve safety and patient flow in the department.
- Ensure the promotion and control of infection at all times and in all areas within medical care.
- Ensure the security of patients' confidential and personal information at all times within medical care.
- Ensure the safety of patients at all times within medical care including ensuring sufficient staff are on duty to monitor and provide care and treatment to the patients. The trust should ensure patients are not left unattended in the ambulatory care department as a result of staff lone working.
- Ensure that the privacy and dignity of patients in medical care is respected and ensure that breaches of the national mixed sex accommodation do not occur.
- Ensure that staff in medical care consistently meet the trust target for mandatory training.
- Ensure that handovers take place consistently in medical care when transferring patients between wards and departments. The trust should ensure that assessments were carried out promptly by doctors following patients being admitted to the medical emergency unit.
- Ensure that there were clear pathways in medical care, including staffing levels, regarding the care of patients who required non-invasive ventilation (NIV).
- Ensure nurse staffing levels on surgical wards meet expected standards as per hospital guidelines to keep patients safe.
- Improve the number of staff on surgical wards who have completed all their mandatory training in line with the hospital target.
- Improve access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Improve the response times to patients complaints within surgery.
- Improve the timely completion of discharge letters to GP's, including reducing the large backlog of letters which have not been sent within surgery.
- Ensure all staff in critical care are compliant with mandatory training and role essential training including child safeguarding at level 3 and current assessment of staff's paediatric competencies (nursing and emergency procedures).
- Ensure there are adequate allocated hours from allied healthcare professionals in critical care to meet national recommendations.
- Ensure there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff in areas where children are cared for in line with national guidance.
- Ensure all staff involved with the care of children are up-to-date with paediatric basic life support and mandatory training.
- Ensure medical and dental staff in outpatients and diagnostic imaging have received training in level two safeguarding vulnerable adults
- Ensure medical and dental staff in outpatients and diagnostic imaging are up to date with mandatory training including adult basic life support, fire training and paediatric life support

Action the hospital SHOULD take to improve

- Ensure that there are suitable quantities of cardiac monitors and trolleys in the emergency department to ensure that they keep people safe at times of crowding.
- Ensure that alcohol and substance misuse support is available in the emergency department for patients who require it.
- Ensure that the executive team is more engaged with staff in the emergency department and plan times of visits better to prevent a negative impact on staff morale.

Outstanding practice and areas for improvement

- Ensure that equipment used in for personal care within medical care services is fit for purpose and that staff could provide assistance promptly if the patient became unwell while using equipment. This relates to showers which staff had to lift a chair over a lip for patients who could not step over to access.
- Ensure that clinical equipment in medical care, such as needles and blades were stored securely. The trust should ensure the safe storage of medicines, including creams and ointments at all times. This should include ensuring that medicines were stored following manufacturers guidelines.
- Ensure that where oxygen cylinders were stored in medical care, there was appropriate signage to inform staff and visitors to the area.
- Ensure that staff working in all departments in medical care have access to emergency equipment and medicines in order to be able to respond promptly to medical emergencies.
- Ensure within medical care that care documentation, including care plans, pain and risk assessments were completed in sufficient detail to inform staff of the individualised care and treatment that was required for each patient.
- Ensure that nursing staffing levels in medical care consistently met the assessed and agreed staffing establishment for all wards and departments.
- Ensure that within medical care performance against national audits is improved.
- Ensure that within medical care the patient's confidentiality was consistently respected when requiring assistance with interpretation and/or translation.
- Ensure that within medical care the complaints process was followed in a timely way and in accordance with the trust policy and procedure.
- Ensure that staff within medical care are consistently informed and knowledgeable about the risk registers for their wards and departments.
- Complete NEWS scores within surgery.
- Improve referral to treatment time target compliance for surgical patients.
- Ensure fabric curtains in critical care are replaced by disposable curtains to meet national standards.
- Ensure processes to monitor and audit compliance with cleaning processes are in place in critical care.
- Ensure effective processes to learn from mortality and morbidity meetings in critical care.
- Ensure staff check essential equipment daily in line with policy in critical care.
- Ensure patients' allergies are always documented and that staff sign for all medicines they administer in critical care.
- Ensure the safe storage of medical gases in critical care.
- Ensure all patient medical records in critical care are stored securely.
- Ensure practice guidance is regularly reviewed and updated in critical care.
- Continue to support the clinical nurse educator role in critical care to comply with national recommendations.
- Review the training and competency assessment of medical staff in critical care to ensure there are always staff on duty who are airway competent.
- Review paediatric competencies and training within the nursing staff in critical care, to ensure this is up-to-date and current.
- Explore the improvement of the patient toilet in critical care to include shower facilities so that these facilities are not shared with relatives.
- Review the arrangements for the provision of follow-up clinics in critical care to ensure these are sustainable.
- Ensure staff have access to appropriate equipment necessary in children's services to carry out their roles and provide care effectively and efficiently.
- Ensure all staff involved in the care and assessment of children and young people have safeguarding training in line with intercollegiate guidance.
- Ensure that systems are in place to ensure case conference notes of vulnerable children are filed in their records in a timely manner.
- Consider the wellbeing of staff within children's and young peoples services in terms of regular access to rest breaks and hydration.
- Consider mechanisms which could improve the connection of, and communication between, front line staff and divisional leaders within children's and young peoples services.
- Consider options for improving the connection between the Women and Children's division and the rest of the trust, together with considering the representation of children's services at board level.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.

Outstanding practice and areas for improvement

- Ensure that departments within outpatients have access to resuscitation equipment in line with hospital policy
- Provide leaflets within departments in outpatients and diagnostic imaging that are available in different languages.
- Ensure access for bariatric patients in outpatients is improved so they can be assessed and treated without compromising their privacy.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise possible risk and harm caused to patients through excessive waits on outpatient appointments and excessive waits on the reporting of images.
- Make improvements on the backlog in typing time times in outpatients and the delay in letters being sent to GPs
- Ensure arrangements are in place to replace aging diagnostic imaging equipment identified at risk of failure

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9 (1) The care and treatment of service users must (b) meet their needs. Surgery services were not meeting the referral to treatment times for all of the surgical specialties.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 (1) Service users must be treated with dignity and respect 10 (2) the things which a registered person is required to do to comply with 10(1) include (a) ensuring the privacy of the service user We found that patient's confidential and personal information were not always held securely within medical care. We found that the privacy and dignity of patients was not always respected and that breaches of the national mixed sex accommodation occurred.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

12 (1) Care and treatment must be provided in a safe way for service users.

12 (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

We found that processes to ensure that resuscitation equipment, medicine fridges and blood glucose monitors safe in the emergency department were not being followed. There were multiple occasions where daily checks had not been completed putting patients at risk.

(h) the things which a registered person must do to comply includes assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Not all equipment patients used was cleaned thoroughly within medical care. Urine was left unattended and uncovered in toilets for prolonged periods of time and carried in uncovered bedpans through the ward.

There were inconsistencies in the handover when transferring patients between wards and departments in medical care. Assessments were not carried out promptly when patients were admitted to the medical emergency unit.

There were not clear care pathways for patients requiring non-invasive ventilation in medical care.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15 (1) All premises and equipment used by the service provider must be –

This section is primarily information for the provider

Requirement notices

(f) appropriately located for the purpose for which they are being used

There was a lack of toilet facilities for patients within the surgical assessment unit and the theatres recovery area

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints 16 (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Complaints were not always dealt with within 25 working days in line with the hospital policy.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. 17 (2) without limiting paragraph (1) such systems or processes must enable the registered person, in particular, to – (a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of services users in receiving those services).

This section is primarily information for the provider

Requirement notices

The provider must continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department as pace to improve safety in the department.

The service did not meet the Faculty of Intensive Care Medicine (2015) Core Standards for the provision of support from allied health therapies (physiotherapy, dietician, occupational therapy, and speech and language therapy). This also meant the service was not compliant with national guidance from the National Institute for Heath and Care Excellence (CG83)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. There were not sufficient staff on duty in medical care to ensure the safety of patients at all times to monitor and provide care and treatment to the patients. There were not sufficient staff on duty on surgical wards to ensure the safety of patients at all times to monitor and provide care and treatment to patients. There were not always sufficient levels of nursing staff in the children's unit to meet RCPCH guidance. There was no acuity tool in use to support leaders to assess staffing needs when caring for children. In addition doctors of sufficient grade to make decisions about children's care were often covering large areas of the hospital out of hours. This presented a potential risk to the safety of children being cared for by the trust. 18 (2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Requirement notices

We found that there were not sufficient numbers of staff in the emergency department observation unit. Staff had too many competing priorities to monitor and observe patients.

Medical staff in the emergency department were significantly below the trust target for all of the mandatory training modules expected of them. This included paediatric life support, fire safety, infection prevention and control and adult basic life support.

Within medical care staff were not consistently meeting the trust target for mandatory training.

Within surgery staff were not consistently meeting the trust target for mandatory training.

Insufficient staff were compliant with mandatory and role essential training in critical care, including child protection training at level three.

There was no evidence in critical care for the assessment and review of nursing staff's paediatric nursing and emergency procedures' competence.

Immediate access to staff competent in advanced airway management techniques could not always be guaranteed in critical care.

Mandatory training compliance for medical staff within the children's services was very low and placed patients at risk.

Compliance with paediatric basic life support training was low across all staff groups in children's services. This placed patients at significant risk in the event of deterioration.

This section is primarily information for the provider

Requirement notices

Within outpatients and diagnostic imaging staff did not consistently meet the trust target for mandatory training, including safeguarding training.